Exhibit A

Booking Sheet dated January 3, 2006

GENEVA COUNTY JAIL
BOOKING SHEET

#11

Probation Check York
Warrant Book Lyle

Date 1-3-06 Time 5:23 pm

Name Jones Emmitt
(LAST) (FIRST) (MIDDLE)

Alias

Date of Arrest 1- Social Security No. 416-88-7530

Race B Sex M Age 44 Eyes Brn Hair Blk

Ht. 5'10" Wt. 170 DOB 4-22-61 Photo Y F.P.

Address unknown?
(STREET) (APT.) (CITY) (STATE) (ZIP)

Telephone . I.D. No.

NCIC Check

Next of Kin Relationship

Address
(STREET) (APT.) (CITY) (STATE) (ZIP)

Charge FTPX2 Bond Charge Bond

Charge Bond Charge Bond

Charge Bond Charge Bond

ARRESTING OFFICER Kersey
(PLEASE PRINT)

Signature

STATE / COUNTY / HARTFORD / GENEVA / SAMSON / SLOCOMB

BOOKING OFFICER
(PLEASE PRINT)

RELEASE INFORMATION

I have received all properties taken from me by the Geneva County Sheriff's Department.

Signature of Person Released

Date of Release 1-31-06 Time 12:00PM Type of Release PER SAMSON

Signature of Releasing Officer

P.O.E.
OCCUPATION
P.O.B. Samson al
HOLD

WARRANT #
WARRANT #
WARRANT #
WARRANT #

BOOKING SHEET

Inmate Name _____ Date _____ Time _____

HEALTH SCREENING FORM

1. Have you ever had or been treated for: (mark box if answer is yes)

- ☐ a. Asthma
- ☐ b. Heart Trouble
- ☑ c. Hypertension
- ☐ d. Diabetes
- ☐ e. Epilepsy or Seizure
- ☐ f. Drug Addiction
- ☐ g. Alcoholism
- ☐ h. Mental Illness
- ☐ i. Venereal Disease
- ☐ j. Tuberculosis
- ☐ k. Ulcer
- ☐ l. Faintly of recent head injury
- ☐ m. Hepatitis

If any response was yes, please explain and give date of last treatment. _____

Last time in jail 10-2005

2. Are you allergic to anything? NO If yes, what? _____

3. Have you ever been determined to be HIV positive? NO If yes, when? _____

4. Are you currently taking any prescription medication? YES If yes, what? _____
High Blood Pressure ; But not with Lisinopril For what? _____

5. Does the inmate require a special diet prescribed by a physician? NO If yes, what? _____

_____ For what? _____

6. Do you have any other medical or mental problem we should know about? NO If yes, what? _____

BOOKING SHEET

Inmate Name _____ Date _____ Time _____

1. Check One:

✓ This inmate was cooperative in responding to the above questions and allowing me to observe him.

_____ This inmate refused or was unable to cooperate and refused to answer my questions concerning his medical history and/or potential for suicide. Reason for inability:

_____

_____

2. I certify that I have today observed inmate _____, asked him/her the questions listed on the Geneva County Jail's Booking Sheet, and accurately recorded my observation and his/her responses.

Marilyn
Signature of Booking Officer

Date: 1-3-06

Time: 5:28 pm

Exhibit B

Prisoner Activity Sheet
Entry dated January 3, 2006

GENEVA COUNTY JAIL
Prisoner's Activity Sheet

DATE	Prisoner's Name: John Emmet
5-11-05	Placed Co Jail For Pub Intox Geneva PD on 10-15 had a wound on R/S on Belly - 731 put a B-Aid.
5-11-05	Sub released per Geneva
10-6-05	Subject brought in by Samson on charges of FTP, TOP, Poss Drug Para. Bond is set at 2,600.00.
1:30	Kinston - Hold - FTA
1-3-06	Subject brought in by Samson on 2 counts of FTP. Bond set at 1,523.00 Cash As Bond. He brought a bond with him from Samson.
1-24-06	Subject went to W. Kesrass ER for [illegible] problem
1-31-06	Subj. released per Samson

Exhibit C

Affidavit of Sheriff Greg Ward

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
SOUTHERN DIVISION

EMMITT REED JONES,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Civil Action No. 1:06-cv-0044-WHA
	)	
SHERIFF GREG WARD, ET.AL,	)	
	)	
Defendants.	)	

AFFIDAVIT OF GREG WARD

STATE OF ALABAMA)
)
COUNTY OF GENEVA)

1. My name is Greg Ward. I am over the age of nineteen and competent to make this affidavit.

2. I am the duly elected Sheriff for Geneva County, Alabama.

3. I am familiar with the Plaintiff due to his being incarcerated in the Geneva County Detention Facility. However, I do not have personal knowledge concerning the specific allegations in the Plaintiff's Complaint.

4. I have delegated the responsibility for the day-to-day functions of the Geneva County Detention Facility to the Jail Administrator Carl Rowe. As Sheriff of Geneva County, I am responsible for promulgating the policies governing the Jail.

5. I state affirmatively that I neither acted, nor caused anyone to act, in such a manner as to deprive the Plaintiff of any right to which he was entitled.

6. The Geneva County Sheriff's Office has a contract with the City of Sampson. Pursuant to this contract, the Sheriff's Office has agreed to house inmates for the City of Sampson at a charge of $20 per day.

7. The Geneva County, Alabama Sheriff's Office operates the Geneva County Detention Facility pursuant to sound policies and procedures which ensure that the rights of all inmates incarcerated therein are respected. Members of the jail staff are trained both in house and at certified training programs and academies regarding all aspects of their jobs, including the administration of medical care to inmates.

8. Upon admission to the Geneva County Detention Facility, the booking officer completes a health screening form for the inmate.

9. It is the policy of the Geneva County Sheriff's Office that all inmates incarcerated in the Geneva County Detention Facility be allowed to request health care services at any time. Requests of an emergency nature may be made either verbally or in writing, but all requests for non-emergency care must be submitted in writing. Members of the jail staff are charged with the responsibility of accepting requests for medical treatment from inmates and taking appropriate action. Inmates who have an emergency medical problem are taken to the Emergency Room for treatment.

10. With regard to inmates housed for the City of Sampson, the policy of the Geneva County Sheriff's Office is as follows: When a member of the jail staff receives a request for medical treatment from an inmate, it is his or her responsibility to turn that request form over to the on duty jailer or matron. The on duty jailer or matron will then contact the City of Sampson. At that point, the City of Sampson is responsible for taking the appropriate steps in responding to

the request, such as making an appointment with a health care provider and transporting the inmate to his appointment. In the event that an inmate is in need of immediate medical treatment, any Geneva County Detention Facility staff member who becomes aware of that need will transport that inmate to the Emergency Room himself. The City of Sampson would then be notified to come to the Emergency Room and take over from there.

11. The Geneva County Detention Facility is subject to routine maintenance and repairs on a regular basis by the custodian.

12. It is the policy of the Geneva County Sheriff's Office that persons incarcerated in the Geneva County Detention Facility be housed in humane and sanitary conditions. On a daily basis, inmates are given cleaning materials in order that they may sanitize the living areas of their cells, under the supervision of a member of the jail staff. In addition, at any time, an inmate may request cleaning materials, and such materials are routinely provided by members of the jail staff in response to such requests. Common areas of the jail, including hallways and catwalks, are cleaned by trusties every morning. The jail is regularly inspected for cleanliness by jail staff.

13. All inmates, including the Plaintiff, are always provided with a mat and blanket for sleeping in the event that the number of inmates exceeds the number of beds at the jail. Never has the Plaintiff had to sleep on the floor without a mat and blanket. As soon as a bunk becomes available in the cell block due to the release of an inmate, any inmate sleeping on a mat on the floor may move to the bunk.

14. I never received any information or instructions that the Plaintiff was supposed to be six inches off the floor.

15. The Plaintiff was arrested by the Sampson Police Department and incarcerated pursuant to the order of the City of Sampson Magistrate Judge. The Geneva County Sheriff's Office had no involvement in the Plaintiff's arrest or prosecution.

16. The Plaintiff has now been released from the Geneva County Detention Facility per the City of Sampson Magistrate Judge's order.

17. Internal grievance procedures at the Geneva County Detention Facility are available to all inmates. It is the policy of the Geneva County Detention Facility that inmates are permitted to submit grievances and that each grievance will be acted upon accordingly. Inmates are given an inmate grievance form upon their request to complete and return to a detention center staff member for any grievance they may have. It is further the policy and procedure of the Geneva County Detention Facility to place each such grievance in the inmate's file for a record of the same.

18. I never received a grievance from the Plaintiff. Had I received such a grievance, I would have followed procedures and responded to the grievance accordingly. Had the Plaintiff submitted such a grievance, it would have been placed in his inmate file.

19. I swear, to the best of my present knowledge and information, that the above statements are true, that I am competent to make this affidavit, and that the above statements are made by drawing from my personal knowledge of the situation.

GREG WARD

SWORN TO and **SUBSCRIBED** before me this 3rd day of April, 2006.

NOTARY PUBLIC
My Commission Expires: 1-10-09

Exhibit D

Affidavit of Carl Rowe

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
SOUTHERN DIVISION

EMMITT REED JONES,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Civil Action No. 1:06-cv-0044-WHA
	)	
SHERIFF GREG WARD, ET.AL,	)	
	)	
Defendants.	)	

AFFIDAVIT OF CARL ROWE

STATE OF ALABAMA)
)
COUNTY OF GENEVA)

1. My name is Carl Rowe. I am over the age of nineteen and competent to make this affidavit.

2. I am the Administrator for the Geneva County Detention Facility.

3. I am familiar with the Plaintiff due to his being incarcerated in the Geneva County Detention Facility.

4. I state affirmatively that I neither acted, nor caused anyone to act, in such a manner as to deprive the Plaintiff of any right to which he was entitled.

5. The Geneva County Sheriff's Office has a contract with the City of Sampson. Pursuant to this contract, the Sheriff's Office has agreed to house inmates for the City of Sampson at a charge of $20 per day.

6. The Geneva County, Alabama Sheriff's Office operates the Geneva County Detention Facility pursuant to sound policies and procedures which ensure that the rights of all inmates incarcerated therein are respected. Members of the jail staff are trained both in house and at certified training programs and academies regarding all aspects of their jobs, including the administration of medical care to inmates.

7. Upon admission to the Geneva County Detention Facility, the booking officer completes a health screening form for the inmate.

8. It is the policy of the Geneva County Sheriff's Office that all inmates incarcerated in the Geneva County Detention Facility be allowed to request health care services at any time. Requests of an emergency nature may be made either verbally or in writing, but all requests for non-emergency care must be submitted in writing. Members of the jail staff are charged with the responsibility of accepting requests for medical treatment from inmates and taking appropriate action. Inmates who have an emergency medical problem are taken to the Emergency Room for treatment.

9. With regard to inmates housed for the City of Sampson, the policy of the Geneva County Sheriff's Office is as follows: When a member of the jail staff receives a request for medical treatment from an inmate, it is his or her responsibility to turn that request form over to the on duty jailer or matron. The on duty jailer or matron will then contact the City of Sampson. At that point, the City of Sampson is responsible for taking the appropriate steps in responding to the request, such as making an appointment with a health care provider and transporting the inmate to his appointment. In the event that an inmate is in need of immediate medical treatment, any Geneva County Detention Facility staff member who becomes aware of that need

will transport that inmate to the Emergency Room himself. The City of Sampson would then be notified to come to the Emergency Room and take over from there.

10. The Geneva County Detention Facility is subject to routine maintenance and repairs on a regular basis by the custodian.

11. It is the policy of the Geneva County Sheriff's Office that persons incarcerated in the Geneva County Detention Facility be housed in humane and sanitary conditions. On a daily basis, inmates are given cleaning materials in order that they may sanitize the living areas of their cells, under the supervision of a member of the jail staff. In addition, at any time, an inmate may request cleaning materials, and such materials are routinely provided by members of the jail staff in response to such requests. Common areas of the jail, including hallways and catwalks, are cleaned by trusties every morning. The jail is regularly inspected for cleanliness by jail staff.

12. All inmates, including the Plaintiff, are always provided with a mat and blanket for sleeping in the event that the number of inmates exceeds the number of beds at the jail. Never has the Plaintiff had to sleep on the floor without a mat and blanket. In fact, the Plaintiff was provided with two mats on which to sleep. As soon as a bunk becomes available in the cell block due to the release of an inmate, any inmate sleeping on a mat on the floor may move to the bunk.

13. There is a problem with water standing in the shower because of a slow drain. Therefore, inmates must wait for the water to drain between each shower. If an inmate wishes to clean the shower after the water has drained and before he showers, he may request cleaning materials to do so.

14. The Plaintiff was arrested by the Sampson Police Department and incarcerated pursuant to the order of the City of Sampson Magistrate Judge. The Geneva County Sheriff's Office had no involvement in the Plaintiff's arrest or prosecution.

15. The Plaintiff has now been released from the Geneva County Detention Facility per the City of Sampson Magistrate Judge's order.

16. Internal grievance procedures at the Geneva County Detention Facility are available to all inmates. It is the policy of the Geneva County Detention Facility that inmates are permitted to submit grievances and that each grievance will be acted upon accordingly. Inmates are given an inmate grievance form upon their request to complete and return to a detention center staff member for any grievance they may have. It is further the policy and procedure of the Geneva County Detention Facility to place each such grievance in the inmate's file for a record of the same.

17. Upon my review of the Plaintiff's inmate file, there is no grievance filed by him concerning the allegations made the basis of his Complaint, and I never received a grievance from the Plaintiff. Had I received such a grievance, I would have followed procedures and responded to the grievance accordingly. Had the Plaintiff submitted such a grievance, it would have been placed in his inmate file.

18. I certify and state that the documents from Plaintiff's Inmate File provided to the Court which are attached to the Defendants' Special Report are true and correct copies of these records, kept at the Geneva County Detention Facility in the regular course of business. I am the Custodian of these Records.

19. I swear, to the best of my present knowledge and information, that the above statements are true, that I am competent to make this affidavit, and that the above statements are made by drawing from my personal knowledge of the situation.

CARL ROWE

SWORN TO and **SUBSCRIBED** before me this 3rd day of March, 2006.

NOTARY PUBLIC
My Commission Expires: 8/1/09

Exhibit E

Inmate Request Form dated January 13, 2006

GENEVA COUNTY JAIL
INMATE REQUEST FORM

NAME [illegible] Jones CELL 2 5 DATE 01-13-06

TELEPHONE CALL ____ MEDICAL ✓ DENTAL ____ HEARING REQUEST ____

GRIEVANCE ____ VISIT ____ PERSONAL PROBLEM ____ OTHER ____

SHERIFF ____ JAIL ADMINSTRATOR ____ JUDGE ____ NOTARY ____

BRIEFLY OUTLINE YOUR REQUEST AND GIVE TO THE JAILER/MATRON.

I would like [illegible] you [illegible] [illegible] [illegible] [illegible] I need to go to the doctor Because I [illegible] [illegible] [illegible] and [illegible] my back [illegible] I need to go to the [illegible] Thanks [signature] Jones

DO NOT WRITE BELOW!! *FOR SHERIFF'S DEPARTMENT USE ONLY*

ALL REQUESTS WILL BE ROUTED THROUGH JAILER/MATRON

JAILER ____ MARTON ____ JAIL ADMINISTRATOR ✓ SHERIFF ____

JAILER [signature]
SIGNATURE

DATE 1/13/06 TIME 9:24 pm

TO BE PLACED IN INMATE'S FILE

Call (Richard) [illegible]

Central [illegible] PD

Exhibit F

Wiregrass Medical Center Records dated January 13, 2006.

WIREGRASS MEDICAL CENTER 1200 W MAPLE AVE GENEVA AL 36340

EXPECT DATE 1/13/06

EMERGENCY ROOM • OUTPATIENT RECORD

PATIENT NUMBER	TYPE	PATIENT NAME	AGE	BIRTHDATE	SEX	M/S	DATE OF SERVICE	TIME	CLERK INIT.
528747	3	JONES EMMITT	44	4/22/1961	M	DB	1/13/06	12:49	GDC

ADDRESS - LINE 1	ADDRESS - LINE 2	CITY	STATE	ZIP CODE	TELEPHONE
308 S LINE ST		SAMSON	AL	36477	334-898-1276

PATIENT SSAN	NOTIFY IN CASE OF EMERGENCY - NAME	RELATIONSHIP	ADDRESS	TELEPHONE
416887530	HILL JUANTIA	FRIEND	312 RIPPLEY SAMSON AL	334-898-9953

INSURANCE COMPANY	CONTRACT OR GROUP NUMBER	DATE	PLACE	ACCIDENT
		1/12/06	HOME/OTHER ACCID	
		TIME	EVENT	
			FALL	

GUARANTOR NAME	GUARANTOR ADDRESS	CITY	STATE	ZIP CODE	GUAR. TELEPHONE	GUARANTOR
JONES EMMITT	308 S LINE ST	SAMSON	AL	36477	898-1276	

GUARANTOR EMPLOYER	GUARANTOR OCCUPATION	GUAR. EMPLOYER ADDRESS	GUAR. EMPL TELEPHONE
INMATE			

PREV. SERVICE	PREV. SERV. DATE	IF MINOR - PARENT NAME	MED. REC. #	ADMITTING/2ND PHYSICIAN
523404	10/21/05		416887530	AJIT MALVI/

CHARGES	X-RAY	LAB	RESP. TH.	PHY. TH.	EKG	I.V.	DRUGS	SUPPLIES	OTHER	M.D.	E.R. RM	TOTAL DUE

AUTHORIZATION FOR TREATMENT, GUARANTEE OF PAYMENT , ASSIGNMENT OF INSURANCE BENEFITS

1. The undersigned has been informed of the emergency treatment considered necessary for the above named patient, and that treatment and procedures will be performed by physicians, members of house staff and employees of the hospital. Authorization is hereby granted for such treatment and procedures. The undersigned has read the above authorization and understands the same and certifies that no guarantee or assurance has been made as to the results that may be obtained.
2. The undersigned agrees to pay for services rendered by Hospital upon release of patient.
3. I/we hereby assign any hospital benefits, sick benefits, injury benefits due to a liability of a Third party, payable by any party, for the above patient, to Hospital unless I pay the account in full upon release of patient.
4. I/we hereby authorize the 'Administrator of Hospital' to furnish from its records any information requested by the before mentioned insurance companies in connection with the above assignment. I do hereby appoint the 'Controller' of Hospital as my lawful attorney to endorse for me any checks made payable to me for benefits or claims collected under the above assignment and to apply any credit balance to any other account I may owe said hospital.

DATE TIME SIGNED PATIENT SIGNED GUARANTOR

CHIEF COMPLAINT (If Accident State How, When, and Where)

TEMP.	PULSE	RESP.	B/P	ALLERGIES	MEDICATIONS - HOME	E.R. PHYSICIAN	TET. TOX.

NURSES NOTES:

NURSE'S SIGNATURE (RN OR LPN)

LAB DATA (Including X-Rays, EKGs, etc.)

PHYSICIAN'S REPORT

DIAGNOSIS:

TREATMENT:

CONDITION ON DISC: IMP | STABLE | EXPIRED

INSTRUCTIONS TO PATIENT:

FOLLOW-UP WITH M.D.

PATIENT'S SIGNATURE ON DISCHARGE DATE - TIME OF DISC PHYSICIAN'S SIGNATURE M.D.

Wiregrass Medical Center
1200 W. Maple Avenue
Geneva, Alabama 36340

528747

James Emmett

CONDITIONS FOR TREATMENT

1. **MEDICAL AND SURGICAL CONSENT FOR TREATMENT:** The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to furnish the necessary treatment, surgical procedures, anesthesia, x-ray examinations or treatments, drugs and supplies as may be ordered or requested by the attending physician(s). The undersigned acknowledges that no guarantee or assurance has been made as to the results of treatment, surgery or examinations in the hospital. The undersigned recognizes that all physicians furnishing services to the patient may be independent contractors and are not employees or agents of the Hospital.

2. **RELEASE OF INFORMATION:** The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to release to any insurers, their representatives or other third parties confidential information (including copies of records) relative to this hospitalization. This authorization includes, but is not limited, to the release of information relating to drug, alcohol and or psychiatric treatment as specified in Federal Regulation 42, CFR part 2. I further authorize any physician or institution that attended the patient previously to furnish medical records or information which may be requested by the Hospital or attending physicians.

3. **RELEASE FROM LIABILITY FOR VALUABLES:** I have been made aware the WIREGRASS MEDICAL CENTER provides facilities for the safe keeping of my valuables and therefore, I release the Hospital from any responsibility due to loss or damage of my clothing, money, jewelry, or other items of value that I might keep at my bedside, or that may be brought to me by my friends and relatives.

4. **GUARANTOR AGREEMENT:** The undersigned agrees, whether he signs as agent or patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account of the Hospital in accordance with the regular rates and terms of the Hospital. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts bear interest at the legal rate.

5. **ASSIGNMENT OF INSURANCE BENEFITS:** In the event the undersigned and/or patient is entitled to Hospital benefits of any type whatsoever arising out of any insurance policy or any other party liable to the patient, such benefits are hereby assigned to WIREGRASS MEDICAL CENTER for application to the patient's bill. It is agreed that the Hospital may receipt for any such payment and such payment will discharge the said insurance company of all obligations under the policy to the extent of such payment. The undersigned and/or patient agrees to be responsible for charges not paid by this assignment.

THE UNDERSIGNED CERTIFIES THAT HE HAS READ OR HAD THE FOREGOING INFORMATION EXPLAINED, HAS RECEIVED A COPY, AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

Date 1-18 20 06 James Emmett
Patient

Witness Gloria Cox

Patient's Agent or Representative

Relationship to Patient

ASSIGNMENT OF MEDICARE BENEFITS:
PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST

"I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services or authorize such physician or organization to submit a claim to Medicare for payment to me. I understand that I am responsible for Part A deductible for each spell of illness, the Part B deductible for each year, the remaining 20% of reasonable charges and any personal charges incurred."

Date | Signature | Relationship to Patient

ACKNOWLEDGEMENT OF MEDICARE

I hereby declare I am a participant in the Medicare Program and I am not enrolled in a health maintenance organization, (H.M.O.), or any other pre-paid group practice. I understand that if it is found that I am a participant in any of the above mentioned practices, I will be considered a self-pay patient required to pay in full immediately.

Date | Signature | Relationship to Patient

Coding Summary Form

Patient Name:	JONES, EMMITT	**Facility:**	Wiregrass Medical Center	**Payor:**	PB1, PRIVATE PAY DEMAND BILL
MRN:	416887530	**Admission Dx:**	847.0	**Reimbursement:**	
Account #:	528747	**Admission Date:**	01/13/2006	**DRG:**	
Sex:	M	**Discharge Date:**	01/13/2006	**MDC:**	
DOB:	04/22/1961	**LOS:**	1	**Weight:**	
Age:	44y	**Attending Provider:**	994000	**AMLOS:**	
Patient Type:	O			**GMLOS:**	
Visit Type:	O	**Discharge Status:**	01, Discharged to home or self-care (routine discharge)	**Coding Status:**	Complete

Dx	Code	Description
1	847.0	Sprain/Strain of Neck
2	E888.9	Unspecified Fall

Px	Code	Description	Date	Surgeon

CPT	Code	Description	Modifier	SVC Date	Surgeon

Notes

Note Type	Assigned Date	Memo

Coder: **TRACEY** 01/16/2006

WIREGRASS MEDICAL CENTER

1200 WEST MAPLE AVENUE
GENEVA, ALABAMA

RADIOLOGY REPORT

NAME: JONES EMMITT
AGE: 44 **SEX:** M
DOB: 04/22/1961
STAY TYPE: E.R. ROOM:
ADMIT DATE: 01/13/06
ACCT NUMBER: 528747
LOCATION:
TRANS DATE: 1/13/06

PATIENT PHONE: 334/898/1276
ORDERING PHY: AJIT MALVI
ADMITTING PHY: AJIT MALVI
REFERRING PHY:
FAMILY PHY:
XRAY NUMBER: 20336
MR NUMBER: 416887530
TRANS INITIALS: SR

<=X-RAY ORDER=> COMPLETE:01/13/06 13:21 ST 36672
Reason for Procedure: FALL LAST P.M.
CERVICAL SPINE MIN. 4V 72050 COMPLETE:01/13/06 13:21 SKT 36686

*** UNSIGNED TRANSCRIPTIONS REPRESENT A PRELIMINARY REPORT AND DOES ******
NOT REFLECT A MEDICAL OR LEGAL DOCUMENT ***

CERVICAL SPINE 5 VIEWS: THE ODONTOID IS INTACT. VERTEBRAL BODY HEIGHTS ARE MAINTAINED. DISC SPACE NARROWING IS PRESENT AT C6/C7, C7/T1 AS WELL AS C5/C6 AND TO A LESSER DEGREE AT C4/C5. NO DEFINITE NEURAL FORAMINAL ENCROACHMENT IS IDENTIFIED. MARGINAL OSTEOPHYTES ARE NOTED FROM C4 TO C7. NO SUBLUXATION IS EVIDENT.

OPINION: MODERATELY SEVERE CERVICAL SPONDYLOSIS.

JOHN C. TOMBERLIN, M.D.

JONES EMMITT E.R.
526747 AJIT MALVINDER SINGH
DOB-04/22/61 44 MALE
01/13/06

Emmett Jones 4-22-61

(5)

Wiregrass Medical Center
ER Triage Record

Addressograph

( ) Emergent (✓) Urgent ( ) Non-Emergent

ER/ROOM

Triage Notes: C/o pain rt side neck & shoulder into rt side of back - Sts fell last p.m. - inmate @ Co. jail - Hx of fall w/ past also -

Time: 1245
Temp: 98.6
Pulse: 84
SpO2: Resp: 12
Room Air: ( ) BP: 160/96
O2:

Allergies: NKDA

Tetanus: Weight: LMP:

Family Physician: Ø

RN Signature: L Hughes RN

Current Medications	Dose	Frequency	Last Dose
BP med (Diltiazem)	240mg	da	1 wk ago
Celebrex		~~da~~ 4# TID	1 wk ago

Disposition: Home() Dr. Office() Surgery () Expired() Adm Rm# AMA/LWBS() Date/Time: 1-13-06

Transfer to Back to jail C/O Dr. Via 1330

(5)

HOSPITAL
PHYSICIAN ORDER FORM : *GENERAL MEDICAL*

JONES EMMITT E.R.
524747 AJIT MALVINDER SINGH
DOB-04/22/61 44 MALE
01/15/05

LABORATORY ORDERS

Order Time	*LAB TEST*	Time Order Sent
	CBC	
	BMP	
	CMP	
	PT / PTT	
	Cardiac profile	
	Liver profile	
	Amylase	
	Lipase	
	Serum preg test	
	Urinalysis	
	Urine C & S	
	Urine preg test	
	Blood cultures	
	Thyroid profile	
	drug levels:	

RADIOLOGY ORDERS

C-Spine

Order Time	*X-RAY*	Time Order Sent
	KUB	
	Abd - flat / upright	
	CXR— PA/lateral	
	IVP	
	US: ☐ GB ☐ aorta ☐ kidney ☐ pancreas	
	CT scan: ☐ abdomen ☐ pelvis ☐ head contrast: ☐ IV ☐ po ☐ none	

CARDIOPULMONARY

Order Time	*TEST*	Time Order Sent
	EKG	
	ABG	
	Sputum gm stain/C&S	

NURSING PROCEDURES

- ☐ Cardiac monitor
- ☐ Pulse Oximetry
- ☐ Continuous BP monitoring
- ☐ Oxygen :
- ☐ Foley Catheter
- ☐ NGT tube
- ☐ Intravenous line
  - ☐ hep lock ☐ fluid:
  - RATE:
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐

MEDICATION ORDERS

Order time	MEDICATION	Admin time	Nurse	Comments / ReAssessment

DISCHARGE INSTRUCTIONS

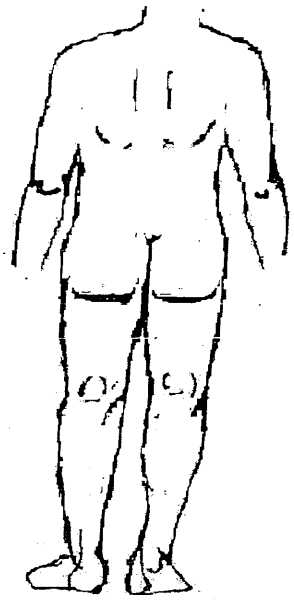
NURSE SIGNATURE	L Hughes RN
PA /NP SIGNATURE	
PHYSICIAN SIGNATURE	

WIREGRASS MEDICAL CENTER
EMERGENCY PHYSICIAN RECORD
PAGE 2

NECK / BACK INJURY / PAIN

(S)

JONES EMMITT E.R.
528747 AJIT MALVINDER SINGH
DOB-04/22/61 44 MALE
01/13/06



PULMONARY
☑ normal
☐ wheezing / rales / rhonchi R /L

CARDIAC
☑ normal
☐ tachycardia / bradycardia
☐ murmur

SKIN
☑ normal
☐ rash

NEUROLOGICAL
☑ normal
☐ focal weakness
☐ focal sensory deficit
☐ abnormal reflexes

PSYCHIATRIC
☑ oriented x 3
☐ disoriented
☐ flat affect

RADIOGRAPHS

Cervical Spine:	☑ normal	*prevertebral soft tissue swelling* *fracture*
Thoracic Spine:	☐ normal	*subluxation* *DJD*
Lumbosacral	☐ normal	*narrowed disc space*
Coccyx	☐ normal	*unchanged from previous X-ray*
Pelvis	☐ normal	
CXR:	☐ normal	☐ abnormal

Other radiographs: _____

LABS

CBC ☐ normal
segs: ____%
bands: ____%
lymphs: ____%

BMP ☐ normal

U/A ☐ normal _____

WOUND REPAIR NOTE

Description: linear / stellate / smooth margins / irregular margins / contaminated / crushed tissue
Location: _____ Length: ____cm
Anesthesia:
topical: _____
local: lidocaine 1% / 2% w/ without epinephrine
other: _____ volume: _____ cc

Cleansing:
irrigation: saline / shurclens / betadine volume: ____ cc
debridement foreign body removal

Wound Repair
☐ wound edges revised
☐ staples_____ ☐ steri-strips only ☐ skin adhesive

	# of sutures	suture size	material	technique
skin			nylon / prolene	simple / running / mattress
subQ			vicryl / chromic	simple / running / mattress
deep			vicryl / chromic	simple / running / mattress

☐ See Additional Wound Repair Notes

ED COURSE

Treatment Response
☐ Tt / Td IM

☐ Old records reviewed ☐ Admission orders written
☐ Discussed with Dr. _____
☐ Counseled patient/family: test results / diagnosis / follow-up

☐ I HAVE PERFORMED A MEDICAL SCREENING EVALUATION
☐ NO EMERGENCY MEDICAL CONDITION EXISTS
☐ FURTHER EVALUATION NEEDED TO RULE OUT AN EMC

CLINICAL IMPRESSION

Acute Cervical Strain	Acute Neck Pain	Cervical Spine Fracture
Acute Lumbosacral Strain	Acute Lumbar Strain	Compression Fracture
Acute Lumbar Fracture	Coccyx Fracture	Coccyx Contusion
Aortic Aneurysm	Renal Colic / UTI	
Exacerbation of Chronic Back Pain	Exacerbation of Chronic Neck Pain	

Radiculopathy: Cervical / Lumbosacral

DISPOSITION (time: _____)
☐ home ☐ admit ☐ transferred ☐ AMA ☐ observation ☐ expired ☐ MSO
Condition: ☐ stable ☐ fair ☐ good ☐ poor ☐ critical ☐ improved
Follow-up: ☐ ED ☐ PMD ☐ on-call _____ in _____ days
Instructions: _____

Rx: Dilaudid 2mg IV #30
Celebrex 200mg PO #30

ATTENDING NOTE
☐ resident/NP/PA note reviewed
☐ I have performed a face to face evaluation of the patient
☐ labs reviewed ☐ x-rays reviewed
☐ I agree with above diagnosis ☐ I have reviewed the treatment plan / concur

_____ Resident / NP / PA
_____ MD / DO

☐ *See Addendum Sheet*

Wiregrass Medical Center
Emergency Department
Nursing Assessment

JONES EMMITT E.R.
529747 AJIT MALVINDER SINCH
DOB-04/22/61 44 MALE
01/13/06

ER/ROOM

Addressograph

Mode of Arrival: ☑ Ambulatory ☐ Stretcher ☐ Ambulance ☐ Arms ☐ Other:_____

Accompanied By: ☐ Self ☐ Family/Friend ☑ Police ☐ Other
Immunizations up to date? ☐ Y ☐ N

Developmental Age Same as Stated Age ☐ Yes ☐ No

How do you prefer to learn? Written ☐ Verbal ☐ Combination ☑

Initial Contact Time: 1245 Allergies: NKDA
Date: 1-13-06

Treatment PTA

None ☑ Cervical Collar ☐ Spineboard: ☐ Splint ☐ Dressings ☐ _____
IV Fluids:_____ Rate: _____ Site: _____
Airway: None ☐ Oral ☐ ET Tube ☐ ☐ Oxygen _____ via ☐ NC ☐ Mask

Nutritional Assessment

Are you on a regular diet? ☑ Y ☐ N
Have you had a recent weight loss or gain? ☐ Y ☑ N
Comments:_____

Respiratory

Respirations: ☑ Regular ☐ Irregular ☐ Shallow ☐ Deep
Breath Sounds: ☐ Bil. Clear ☐ Rhonchi ☐ Rales ☐ Wheezes
Cough: ☐ Productive ☐ Nonproductive
Sternal Retractions? ☐ Yes ☑ No
Dyspnea? ☐ Yes ☑ No
Comments:_____

Circulation

Skin: ☑ Warm ☑ Dry ☐ Hot ☐ Diaphoretic ☐ Cold ☐ Clammy
Color: ☑ Normal ☐ Pink ☐ Dusky ☐ Flushed ☐ Pale ☐ Cyanotic ☐ Jaundice
Edema: ☐ Yes ☑ No
JVD: ☐ Yes ☑ No
Capillary Refill: ☑ Quick ☐ Slow
Comments:_____

Glasgow Coma Scale

Eyes Open:	Spontaneously	4
	To Verbal Command	3
	To Pain	2
	No Response	1
Best Motor Response	Obeys	6
	Localizes Pain	5
	Flexion-Withdrawal	4
	Flexion/Abnormal (Decorticate Rigidity)	3
	Extension (Decerebrate Rigidity)	2
	No Response	1
Best Verbal Response	Oriented/Converses	5
	Disoriented/Converses	4
	Inappropriate Words	3
	Incomprehensible Sounds	2
	No Response	1

GCS Total (3-15):

Neurological

Level of Consciousness: ☑ Alert ☐ Responds to Voice ☐ Responds to Pain ☐ Unresponsive ☐ Lethargic
Orientation: ☑ Appropriate Response ☐ Inappropriate Response
Pupils: Brisk ☐ L ☐ R Sluggish ☐ L ☐ R Nonreactive ☐ L ☐ R
Size: L:_____ R:_____
Visual Acuity: ☐ N/A OD:_____ OS:_____
Movement: ☐ Voluntary ☐ Involuntary

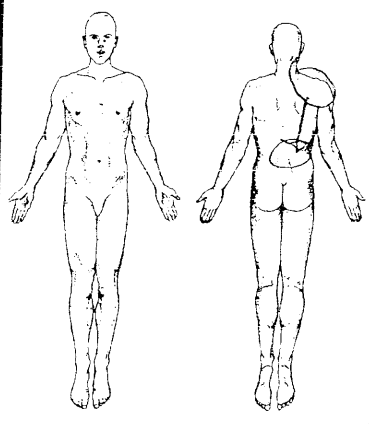
Hand Grasp:	L	R
Strong	☐	☐
Weak	☐	☐
Absent	☐	☐

Slurred Speech? ☐ Yes ☐ No

Abdominal

☐ Distended ☐ Nausea
☐ Vomiting ☐ Diarrhea
☐ Constipation ☑ LBM:_____
Bowel Sounds: ☐ Present ☐ Absent
Comments:_____

Pain/Injury Location



Location (circled above)

Radiation (arrow above)

Laceration (s)

Location(s):_____
Size(s):_____
Bleeding Controlled: ☐ Yes ☐ No
Comments:_____
Full Range of Motion ☐ Y ☐ N
Pulse:_____ ☐ Y ☐ N
Sensation Intact: ☐ Y ☐ N

GU-GYN

Pain in Voiding: ☐ Yes ☐ No
Frequency ☐ Yes ☐ No
Bleeding: ☐ Yes ☐ No
Vaginal Bleeding ☐ Yes ☐ No
Vaginal Discharge ☐ Yes ☐ No
☐ Scant ☐ Moderate ☐ Large
Grav_____ Para_____ Ab_____
Comments:_____

Orthopedic

Ext Deformity: ☐ Yes ☐ No
Full ROM: ☐ Yes ☑ No
Pulse:_____
Cap. Refill: ☐ Brisk ☐ Slow
Temp: ☐ Warm ☐ Cold

Emotional Assessment

Eye Contact ☑ Y ☐ N
Affect: ☑ Normal ☐ Flat ☑ Cooperative ☐ Disoriented ☐ Combative ☐ Anxious

Do you feel safe in your present living environment?
☑ Yes ☐ No
If no, would you like to talk to someone? ☐ Yes ☐ No
Inmate to Jail
Comments:_____

Pain Cont'd

Severity:_____
0 1 2 3 4 5 6 7 (8) 9 10
Exacerabated By:_____

Nurse's Signature

WIREGRASS MEDICAL CENTER

1200 W. MAPLE AVE.
GENEVA, AL 36340
(334) 684-3655

ED-OP
HOME INSTRUCTION SHEET

1. MEDICAL RECORD NO.	2. BILLING NO.	3. A/R NO.

INFORMATION

4. CLASS	5. DATE	6. TIME	7. SRC	8. TYPE	9. SAD

10. PATIENTS LEGAL NAME (L,F,MI)	11. SEX	12. RACE	13. BIRTHDATE	14. AGE	15. HEIGHT	16. WEIGHT	17. SS	18. MS	19.

20. RP	21. NOTIFY IN EMERGENCY	22. HOME TELE	23. WORK TELE	24. HOW PATIENT ARRIVED

25. C COMPLAINT 26. JONES EMMITT E
52P747 AJIT MALVINDER SINGH
DOB-04/22/61 44
01/13/06

OUTPATIENT SURGERY INFORMATION

27. PROC CD	28. PROCEDURE	29. LOC	30. TIME	31. ANES

32. PHYSICIAN CALLED	33. ATTENDING PHYSICIAN	34. FAMILY PHYSICIAN
	SALE	

ED/PCCM

SPRAIN, FRACTURE, & SEVERE BRUISES

- ☐ Elevate the injured part above level of heart to lessen swelling. If pillows flatten, use chair cushions with pillows or blanket for comfort.
- ☐ Ice packs also help prevent swelling, especially during the first 48 hours.
- ☐ Place ice in plastic or rubber bag, cloth covering; after 48 hours, use heat.
- ☐ If you have an elastic bandage, rewrap it if too tight or loose. Remove at bedtime and replace in A.M.
- ☐ If you have a cast, keep it perfectly dry at all times.
- ☐ Wiggle toes or fingers to help prevent swelling in the cast–this should be done often if it does not cause pain.
- ☐ If the part swells anyway or gets cold, blue or numb or pain increases markedly, have it checked promptly.
- ☐ Use crutches.

BACK AND NECK INJURY INSTRUCTIONS

- ☐ USE HEAT OR COLD ON THE INJURED AREA - whichever seems to help the most. Be careful not to burn yourself.
- ☐ Rest as much as possible until you are improved.
- ☐ Avoid positions and movement that make the pain worse.
- ☐ Relax emotionally - if you are tense the problem will on be worse.
- ☐ Gentle but firm massage will increase circulation in sore muscles and helps to clear the soreness.
- ☐ Wear special collar when out of bed.

HEAD INJURY INSTRUCTIONS

Persons who receive blows to the head may have injuries that cannot always be seen by X-ray or examination soon after accident. For the next 24 hours it is important that these instructions be followed:

- ☐ Awaken the patient every two hours, even at night, to be sure he knows where he is and is not confused.
- ☐ Check eyes to see that both pupils are of equal size.
- ☐ Prevent the taking of sleeping pills, tranquilizers or alcohol.
- ☐ Restrict excessive work or play.

Call your family doctor or local hospital immediately if the patient:

- ☐ Develops a severe headache.
- ☐ Vomits more than twice within a short time.
- ☐ Is confused, faints or is hard to awaken.
- ☐ Has a pupil of one eye larger that the other
- ☐ Complains of double vision
- ☐ Shows abnormal behavior such as staggering or walking into things.

X-RAY INSTRUCTIONS

Your X-rays have been read by the attending physician in the Emergency Dept. For your added protection, your X-rays will be reread the next morning by Radiology Dept. If any abnormalities are found that have not been called to your attention, you and your doctor will be called immediately. (Please be certain that the Emergency Dept. has a phone number where you can be reached.) Sometimes fractures or abnormalities may not show up on X-rays for several days. If your symptoms continue or get worse, call your doctor. More X-rays may need to be taken. If you are referred to another physician, come by the hospital and pick up your X-ray and take them with you to the doctor's office. Please call ahead to X-ray Dept.

WOUND CARE (Cuts, Abrasions, Burns, Stitches)

- ☐ Keep the dressings clean and dry.
- ☐ Elevate the wound to help relieve soreness and help speed wound healing.
- ☐ Despite the greatest care, any wound can be infected. If your wound becomes red, swollen, shows pus or red streaks, or feels more sore instead of less sore as days go by, you must report to your doctor right away.
- ☐ Dressing should be changed in _____ days.
- ☐ Treatment rendered _____.
- ☐ Tetanus Toxiod given _____. 250 units of tetanus immune globulin was given. To complete your immunization, you must receive two additional doses of toxoid 4-6 weeks apart. Call your physician for the next dose.
- ☐ Warm soaks to area 4 times daily. 20-40 minutes each time.
- ☐ Continuous warm compresses.

VOMITING & DIARRHEA

- ☐ Do not feed anything for 4 hours.
- ☐ After 4 hours, if there is not vomiting and/or diarrhea, offer 2 tablespoons (1 ounce) of any of the following: clear liquids, Coke, Gingerale, 7-up, weak tea, Gatorade or Jello, water. If patient is hungrey you may add 1 teaspoon of sugar to each ounce of liquid.
- ☐ UNDER NO CIRCUMSTANCES USE MILK OR MILK PRODUCTS.
- ☐ The 2 tablespoons of liquid may be offered every hour. If after 4 hours no vomiting has occured, the amount may be slowly increased.
- ☐ Using no more than ½ glass (4 ounces) of liquid at a time continue this treatment for 24 hours.
- ☐ Contact your doctor's office for further instructions after 24 hours.

GENERAL INSTRUCTIONS

- ☐ Stay in bed/may go to bathroom.
- ☐ Use vaporizor.
- ☐ Drink large amounts of liquids.
- ☐ Take _____ aspirin every 4 hours..
- ☐ Avoid any use of injured part.
- ☐ Allow only limited use of the part.
- ☐ You need not necessarily limit activity.
- ☐ Fill Prescriptions given to you from Emergency Dept. and take as directed.
- ☐ No driving or any activity requiring mental alertness after receiving medication.

FEVER OVER 102

- ☐ Sponge with lukewarm water in the tub.
- ☐ If temperature increases or persists for 24 hours, see your family doctor.

EYE INJURY

- ☐ Any eye injury is potentially hazardous.
- ☐ Any increasingly severe discomfort, redness or sudden impairment of vision should be reported immediately to your physician or eye specialist below.
- ☐ Do not drive with eye patch.

ANIMAL OBSERVATION

Instructions for observation of any animal that may have bitten a human if that animal is available for observation.

- ☐ Have animal taken to Vetennarian for observation.
- ☐ If the owner should refuse to take the animal to the Vetennarian, notify the County Health Officer of the situation.

ADDITIONAL INSTRUCTIONS Follow up as needed - may apply warm moist heat to areas of pain

I hereby acknowledge receipt of all the instructions indicated above. I understand that I have received EMERGENCY treatment only and that I may be released before al my medical problems are known or treated. I will arrange for follow-up care as indicated above. I understand that if my conditions worsen or new symptoms appear, I should contact my Doctor immediately.

PATIENT/PARENT'S SIGNATURE	NURSE'S SIGNATURE	PHYSICIAN'S SIGNATURE
x Emmitt Jones	L Hughes RN	

SCHOOL AND WORK EXCUSE *PATIENT NAME* *DATE*

- ☐ No work for _____ days
- ☐ Light work for _____ days
- ☐ May return to work on _____
- ☐ No school for _____ days
- ☐ No Physical Education for _____ days
- ☐ May return to school on _____

ADVANCE DIRECTIVE
ACKNOWLEDGEMENT

NAME: Emmett Jones SOC. SEC. NO: 416883530

IDENTIFICATION NO: 528747 DATE OF BIRTH: 4-22-61

PLEASE READ THE FOLLOWING FOUR STATEMENTS.

1. I have been given written materials about my right to accept or refuse medical treatments

2. I have been informed of my rights to formulate Advance Directives.

3. I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility.

4. I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:

☐ I HAVE executed an Advance Directive.

☒ I HAVE NOT executed an Advance Directive.

Signed Emmett Jones Date: _____

Witness: _____ Date: _____

Witness: Gloria Cain Date: 1-13-06

Wiregrass Medical Center

Emergency Physician's Charge Sheet Date:

JONES EMMITT
529747 AJIT MALVINDER
DOB-04/22/61 44 MALE
01/13/06

ER/ROOM

Level of Service

19599281	Level I
19599282	Level II
19599283	Level III
19599284	Level IV
19599285	Level V
19599288	Direct Life Support In Transit
19599025	Visit with Surgery
19599291	Critical Care per Hour
19599292	Critical Care per 1/2 hour
19591105	NG Lavage/Aspiration
19599175	Ipecac Admin/Observe Gastric emptying

Airway/Pulmonary

19531500	Endotracheal Intubation
19531511	FB Removal
19532020	Tube Thoracostomy

Vascular Procedures

19536410	Non-Routine Venipuncture
19590780	IV Therapy Requiring MD per hour
19592977	Thrombolysis IV infusion

Cardiac Procedures

19592950	CPR
19592953	Transcutaneous Pacing
19592960	Cardioversion, Elective
19593010	EKG Interpretation

Ophthalmology

19565205	FB
19565210	FB Conjunctival/Embedded
19567938	FB, Eyelid

Ear, Nose, and Throat

19542809	FB Pharynx
19569200	FB External Ear Canal
19569210	Impacted Cerumen
19530300	FB Intranasal
19530901	Anterior Epitaxis, Simple
19530903	Anterior Epitaxis, Complex
19530905	Posterior Epitaxis, Initial

Soft Tissue/Foreign Body Removal

19510120	Sub Q, Simple
19510121	Sub Q, Complicated
19520520	Muscle, Simple
19520525	Muscle, Complex

Nails

19511730	Avulsion/Nail, Simple
19512740	Subungal Hematoma
19511750	Nail Removal

Debridement

19511000	Infected Skin
19511040	Partial Skin Thickness
19511041	Skin, Full Thickness
19511042	Skin and Sub Q Tissue
19511043	Skin, Sub Q, Muscle
19511044	Skin, Sub Q, Muscle, Bone

Hematoma and Abcess

19510060	I&D Simple Abcess, Furuncle
19510061	I&D Simple Abcess, Complicated/ Multiple
19510140	I&D Hematoma Simple
19510160	I&D Puncture Aspiration, Abcess
19546320	Hemorrhoid, Thrombosed

Burns

19516000	First Degree Burn, Initial
19516020	Small Burn, Debride,Dress
19516025	Medium Burn, Debride/Dress
19516030	Large Burn, Debride/Dress

OB/GYN Procedures

19556405	I&D, Abcess, Vulva
19556420	I&D, Bartholin Abcess
19559410	Emergency Vaginal Delivery

Arthrocentesis

19520600	Arthrocentesis, Small Joint
19520605	Arthrocentesis, Intermediate Joint
19520610	Arthrocentesis, Major Joint

Miscellaneous Fractures

19521800	Closed Rib Fracture
19523500	Clavicle
19523720	Closed Phalangeal Shaft
19526750	Closed Distal Phalangeal
19528490	Closed Fracture, Great Toe
19528510	Closed Phalanx other than Gr. Toe

Miscellaneous Closed Dislocations

19521480	TMJ Uncomplicated
19523650	Shoulder w/ Manipulation
19524640	Nursemaid's Elbow
19526700	Finger, MP Joint
19526770	Finger, IP Joint
19528660	Toe IP Joint

Miscellaneous Procedures

19553570	Urine Catheterization, Simple
19553575	Urine Catheterization, Complex
19562270	Spinal Puncture
19564450	Digital Block
19582270	Stool for Occult Blood
19593042	Rhythm Strip Interpretation

Repair/Simple- Single Layer

Scalp, Neck, Axillae, External Genitalia, Trunk, and/or extremities

19512001	2.5 cm or less
19512002	2.6 - 7.5 cm
19512004	7.6 - 12.5 cm
19512005	12.6 - 20.0 cm
19512006	20.1 - 30.0 cm
19512007	Over 30.0 cm

Repair/Simple- Single Layer Cont'd

Face, Ears, Eyelids, Nose, Lips, and/or Mucous Membranes

19512011	2.5 cm or less
19512013	2.6 - 5.0 cm
19512014	5.1-7.5 cm
19512015	7.6 - 12.5 cm
19512016	12.6 - 20.0 cm
19512017	20.1 - 30.0 cm
19512018	Over 30.0 cm
19512020	Superficial WD Dehis
19512021	Superficial WD Dehis-Pack

Repair/Intermediate-Layered

Scalp, Axillae, Trunk, and/or Extremities

19512031	2.5 cm or less
19512032	2.6 - 7.5 cm
19512034	7.6 - 12.5 cm
19512035	12.6 - 20.0 cm
19512036	20.1 - 30.0 cm
19512037	Over 30.0 cm

Neck, Hand, Feet, and/or External Genital

19512041	2.5 cm or less
19512042	2.6 - 7.5 cm
19512044	7.6- 12.5 cm
19512045	12.6 - 20.0 cm
19512046	20.0 - 30.0 cm
19512047	Over 30.0 cm

Face, Ears, Eyelids, Nose, Lips, and/or Mucous Membranes

19512051	2.5 cm or less
19512052	2.6 - 5.0 cm
19512053	5.1 - 7.5 cm
19512054	7.6 - 12.5 cm
19512055	12.6 - 20.0 cm
19512056	20.1 - 30.0 cm
19512057	Over 30.0 cm

Repair/Complex-Reconstructive or Complicated Wound Closure

Trunk

19513100	1.1 - 2.5 cm
19513101	2.6 - 7.5 cm

Scalp, Arms, and/or Legs

19513120	1.1 - 2.5 cm
19513121	2.6 - 7.5 cm

Forehead, Cheeks, Chin, Mouth, Neck, Axillae, Genitalia, Hands, and or Feet

19513132	1.1 - 7.5 cm

Eyelids, Nose, Ears, and/or Lips

19513151	1.1 - 2.5 cm
19513152	2.6 - 7.5 cm

Miscellaneous

19520552	Injection-trigger point 1-2 mus
19520553	Injection-trigger point 3 + mus

Wiregrass Medical Center
ER Level of Service Charge Sheet

JONES EMMITT E.R.
528747 AJIT MALVINDER SINGH
DOB-04/22/61 44 MALE
01/13/06

ER/ROOM

		Circulatory
		Jugular,Cutdown, Central Line
	19636430	Blood Administration
	19692960	Cardioversion, Mechanical
	19692950	Code Blue
	19692953	External Pacemaking
	19631500	Intubation
	19690471	Vacine Admin. (other than Rabies)
	19690675	Vacine Administration (Rabies)
	19690784	Medication Administration IV
	19690782	Medication Administration IM or SQ
	19690780	IV infusion-up to 1 hour
	19690781	IV infusion-each additional hour
	19649080	Paracentesis
		Peritoneal Lavage/Tap
	19632000	Thoracentesis
	19633010	Pericardiocentesis
	19632002	Chest Tube Insertion
		IV Hydration
		ENT
		Eye Irrigation
		Eye Exam/Corneal Abrasion
		Foreign Body Removal Ear
		Foreign Body Removal Nose
		Irrigation Ear
		Nose Bleed/Nasal Packing
		Rust Ring (Foreign Body Removal)
		Respiratory
	19631603	Tracheotomy
	19631605	Cricothyrotomy
	19631603	Trach Change
		Gastrointestinal
	19691105	Gastric Lavage or NGT insertion
	19643760	Gastrostomy Tube Placement
		Genitourinary
	19659409	Delivery/Birth
		Supra Pubic Cath, or Turkey Tray
	19651700	Irrigation of Catheter
		Pelvic Exam

		Integumentary
	19611760	Repair of Nail Bed
	19611740	Subungal Hematoma
		Dressing Application
	19610120	FB removal
	19620000	I&D Abcess
	19600000	Laceration Repair (simple,intermed)
	19610000	Laceration Complex
	19611040	Debridement
	19616020	Treatment of Burns
		Orthopedics
		Behr Block/Regional Block
	19629500	Casting/Splinting
	19629705	Removal or Revision of Cast
		Tx of fx/dislocation with manipulation
	19620950	Compartmental Syndrome
		Neurological
	19662290	Lumbar Puncture
		Other
	19682962	Glucose fingerstick
		Treatment Level
	19699211	Low Level E/R
	19699281	Emergency WD
	19699282	Emergency I
		Emergency I with procedure
✓	19699283	Emergency II
		Emergency II with procedure
	19699284	Emergency III
		Emergency III with procedure
	19699285	Emergency IV
		Emergency IV with procedure
	19699291	Critical Care
		Critical Care with procedure
		Observation I
		Observation II
		Observation III